TRANSITION PLANNING CHECKLIST

for young people with a chronic gastrointestinal condition

These checklists are designed to stimulate thought and discussion about transition issues at various developmental stages for young people with chronic gastrointestinal conditions. They are intended to serve as a guide only.

It is impossible for any one health professional to have the time, or all the skills required, to address all the issues that might be relevant for a young person and their family. It is, therefore important that a young person and his/her family are given information on resources and that other professionals are involved to address specific issues relevant to the adolescent. Health professionals, such as occupational therapists, social workers, youth health teams and psychologists can support young people in the areas of educational and vocational planning, social connectedness and sexual health.

These checklists can be used by professionals, parents and young people either on their own, or in conjunction with other more detailed tools such as the *Assessment for Readiness Checklist* available on the Transition website. A list of relevant adolescent websites can be also be found on the transition website

For more information on checklists or adolescent services look at the transition website:

www.health.nsw.gov.au/gmct/transition

HEALTHCARE PROVIDER TRANSITION CHECKLIST

Checklist is adopted from the North American Society for Pediatric Gastroenterology, Hepatology and Nutrition

AGE	YOUNG PERSON	HEALTH CARE TEAM
Early adolescence **12-14 years** ***New knowledge and reponsibilities*** *The young person and family are introduced to the transition process. The young person begins to participate in his/her own care. Skills are supported and practised at home with the family.*	❑ Can describe GI condition and how it affects daily living ❑ Can name medications, amount and times taken ❑ Can describe common side effects ❑ Can manage normal medications at school ❑ Knows doctors and nurses names, contact numbers and roles	❑ Educate the young person to be able to describe their chronic health condition including: medications taken, how to get help and the signs of deterioration. ❑ Encourage the young person to ask questions during each appointment, direct questions to them and begin to set specific self-management goals such as knowing how to make or change an appointment. ❑ Discuss purpose of Medical Alert ID bracelet and emergency treatments if relevant, and advise how to seek help from others. ❑ Discuss transition and why it is undertaken. Direct them to the transition website **www.health.nsw.gov.au/gmct/transition** ❑ Talk about the importance of having a GP that they trust. Encourage them to appropriately use their GP ❑ Discuss puberty changes, differences from peers and the impact of puberty on their condition and discuss where the young person and parents can obtain information about sexuality and puberty. ❑ Talk to the young person about social activities, school, peer involvement and supportive relationships. **Parents:** ❑ Discuss with parents how they might facilitate their adolescent's independence and encourage them to prepare and support their adolescent to start asking their health care team questions ❑ Raise the idea of in the future allowing the young person to spend time with the doctor without parents being present
Mid adolescence **15-16 yrs** ***Building knowledge and practicing independence*** *The adolescent and family gain understanding of the transition process and the expectations of the adult system. The young person practises skills, gathers information and sets goals for*	❑ Spends time with their doctor without parents, knows medical history and is able to answer questions about their condition ❑ Knows names and purpose of tests that are done regularly ❑ Knows the triggers for a flare up of their condition ❑ Understands the impact of drugs and alcohol on their condition ❑ Knows about transition to adult services	❑ Discuss the importance of preparing the young person for independence and address any anxieties ❑ Focus on the patient rather than parent/carer, provide the opportunity to meet with the young person alone and allow the young person to determine when the parent or carer is present ❑ Inform the young person of what aspects of care the parent/carer must legally be informed about and inform them that their GP will be updated ❑ Continue to set specific self management goals such as filling a prescription, making appointments, keeping a list of medications and medical contact information in wallet ❑ Discuss in more depth the impact of drugs, alcohol, and non adherence and the impact of their condition on sexuality and fertility

participating in his/her care.	❑ Has a GP they trust and use appropriately	❑ Discuss timing of transfer to adult health service ❑ Regularly update the young person's GP about their progress and transition plan **Parents:** ❑ Discuss with parents their changing role as support person rather than main care giver to young person. ❑ Encourage time for the parents to express their own issues or concerns about transition ❑ Explore ways that parents can help educate and support their adolescent to further increase independence
Late adolescence ***Taking charge*** *The young person and family prepare to leave the paediatric system with confidence.* *The young person uses independent behaviours (as able) to move into the adult system.*	❑ Can manage all aspects of their condition both at home and at school/ work ❑ Sees doctor alone or chooses who is present ❑ Carries emergency information in wallet and know how to get emergency help ❑ Knows how to get further information about medical condition ❑ Understands the adult health system, who pays for appointments and how to make appointments ❑ Understands the process for referral to the adult health services, chooses and meet their new team ❑ Knows the name and contact number for the GMCT Transition Coordinator in their area	❑ Discuss choices for adult care. Assist in choosing adult providers (specialists/hospitals/community,GP). ❑ Discuss the process of how the young person will be introduced to the adult health team ❑ Check that the young person knows who to contact for future health needs - names and telephone numbers of health team and GMCT Transition Coordinator (TCC). ❑ Refer to the Transition Coordinator using referral form ❑ Ensure the young person has met with the adult specialist / GP before discontinuing paediatric care. ❑ Send a summary of paediatric care to the adult specialist/s and GP. Provide a copy to the young person ❑ Check that the young person has a plan of who to contact in the event that new care arrangements at the adult facility do not meet expectations. Encourage them to feedback about their encounter with their new health care providers. ❑ Discuss genetic risks, sexuality, fertility and mental health issues ❑ Have the young person identify person(s) he/she can contact for help or advice. ❑ Discuss in more depth the use of smoking, alcohol and drugs, the interaction with medication and impact on illness/condition and any other risk-taking behaviour. ❑ Discuss employment or vocational options. Identify any needs for personal assistance in care or issues of living away from family. **Parents** ❑ Discuss with parents their changing role as support person rather than main care giver to young person. ❑ Encourage parent to feedback issues around the transition process and make sure they know name and contact of the GMCT Transition Coordinator for their area